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The Journal of the Fort Logan Mental Health Center is a quarterly, scientific journal which publishes original articles on new treatment methods of emotional disturbances, with emphasis on hospital community psychiatry and therapeutic milieu.

The Fort Logan Mental Health Center is a new state hospital which will eventually serve half of the population of the state of Colorado. Its organization follows as much as possible the recommendations of the Joint Commission on Mental Health. Concepts of milieu therapy are strongly utilized, with the emphasis on expansion of professional roles and the involvement of the patient's family and his community as much as possible in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. One-half of its patients are in day care, and evening care is being instituted. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient through admission, treatment, and outpatient care.

THE NEW THERAPEUTIC COMMUNITY

MAXWELL JONES, M.D.,* *Physician Superintendent*
Dingleton Hospital, Melrose, Scotland

With the plans for comprehensive community mental health centers starting in 1965 as epitomized in the President's message to Congress, it is obvious that the importance of Fort Logan in the national scene is unique. To the best of my knowledge, with the possible exception of San Mateo Community Hospital, Fort Logan has the model on which the President's plans could be implemented. In fact, it could be said that the San Mateo Community Clinic is complementary to the Fort Logan Center, in that the former has evolved from an existing community hospital with all the advantages and disadvantages which that implies, whereas Fort Logan has started without existing traditions and expectations and is attempting to develop in ways which are appropriate to the task in hand.

My very brief but very enjoyable encounters with the Fort Logan project certainly do not justify my claiming any real knowledge of its structure and function. Nevertheless, I have the impression that it epitomizes the best aspects of social psychiatry, and to me the term *social psychiatry* implies two separate concepts. One is that psychiatry cannot work in isolation, but must pay more attention to the social environment, either intra- or extramural, in which it operates and must of necessity turn increasingly to the social sciences for direction and inspiration. At the same time, the concept of social psychiatry to me implies a sensitive awareness of the social environment as it affects patients, their relatives, significant others, and the staff of the treatment team. The concept of a therapeutic community which originally was limited to a hospital community must now be widened to include

*Dingleton Hospital, Melrose, Scotland.

the outside community. We are only beginning to understand the particular qualities and needs of community psychiatry, and in the foreseeable future it would seem that psychiatry should be closely linked in its intra- and extra-mural dimensions.

This applies particularly to training, which still tends to be done in the hospital setting, although one would expect that it would be done increasingly in the field too. My own belief is that at the present stage of our knowledge the training of psychiatric residents must be done in the hospital setting or at mental health centers, such as Fort Logan. An inpatient population has the great advantage that the social dimension is readily observable and that ward meetings followed by staff seminars to discuss the interaction between staff and patients in such a meeting afford the best available setting in which multidisciplinary training in social psychiatry can be carried out. I would argue that a psychiatrist who becomes sensitive to the social forces in the environment in a ward will have comparatively little difficulty in translating these skills to the social environment in community psychiatry, whether he is doing a home visit or seeing a patient in an out patient department. He will automatically want to integrate the skills of the various disciplines and involve the family in the treatment situation, etc.

In the President's message to Congress he implied that the new mental health centers should be either associated with existing community hospitals or in specially developed mental health centers. From our experience in Britain it would seem that there are real difficulties about the former model. The overall culture of the general hospital is usually inevitably felt by the smaller psychiatric unit, and even when full autonomy in an administrative sense is obtained, the mores of the larger hospital still affect the smaller unit. Psychiatric nurses tend to feel that they are at some disadvantage with the nurses in the general hospital. If, for example, it appeared appropriate that the psychiatric nurses should cease to wear uniforms, I think that this would create considerable problems which would be relatively absent in an independent mental health center like Fort Logan.

My belief is that the therapeutic community will be an invaluable aid to training programmes. It does much to offset the stereotyped training which doctors and nurses receive in their general

training and which does little or nothing to prepare them for group work or to sensitize them to their social environment. In the setting of a therapeutic community it is possible to develop a multi-disciplinary training, particularly if social science personnel are attached to the hospital. Thus, the gaps in knowledge and awareness which are apparent in both the doctors and nurses in training can be remedied to some extent. The time must come when both doctors and nurses are getting much more social science in their undergraduate years, and already there are signs of this happening. In due course it should be much easier to integrate the work of doctors, nurses, social workers, psychologists, occupational therapists, and in fact all people coming in contact with the patient. There would seem to be no reason why most, if not all, of these disciplines should not become cotherapists, particularly in a group setting, or why they should not take groups in their own right.

It is questionable if the psychiatrist can retain his leadership in a setting of this kind indefinitely. As de Smit (1) has pointed out, there is no reason why the psychiatrist should be seen as the leader in the mental health field. He may know something about mental illness, but there is no reason why he should pose as an authority on mental health. He may reasonably operate as a consultant in a mental health team, but the leader should, more appropriately, be drawn from the social science disciplines.

If one envisages community psychiatry developing along these lines, then it is clear that one will get a considerable degree of role blurring and sharing of responsibility. Under these circumstances it is difficult to see how the discrepancy in the various pay scales of different disciplines as currently found can continue. However, President Kennedy anticipates the increasing involvement of private psychiatrists in the new community psychiatry which is being planned, and I doubt if more equable distribution of rewards will appeal to them. It may be, however, that the very fact that private psychiatrists are given ready access to psychiatric services run by states, local communities, etc. will lead to much more interesting work for them and a far better understanding of the allied professional groups. In fact, the whole orientation of private psychiatry might well be expected to change.

In both Britain and the United States official statements have implied the progressive depopulation of mental hospitals, with a

fifty percent diminution in bed occupancy in from ten to fifteen years. Neither group seems to have paid sufficient attention to the "revolving door" phenomenon or to the steadily increasing re-admission rates.

G. F. Rehin and F. M. Martin (7) have made a very interesting study entitled "Psychiatric Services in 1975." In this they analyze many of the statistical assumptions which the Minister of Health presented to Parliament in January, 1962 (4), and can find no good reason why the mental hospital should be seen as diminishing in importance. Of course, mental hospitals in Britain are relatively much smaller and closer to the populations which they serve than in America. They express the opinion that they have been unable to find any evidence which suggests that the assumptions or possible consequences of the plan have been systematically examined. By contrast, the publication by the Department of Health for Scotland entitled *Hospital Plan for Scotland* (5) is seen as being more realistic. They point out that we have no way of telling how far local authorities will assume the responsibilities in the fields of prevention and mental aftercare which they are expected to undertake, and in this context it remains to be seen if general practitioners are likely to increase their responsibilities for the care of chronic mental patients in the community without the support of local authority services. They see the need for many pilot experiments to assess the different models for total mental health services.

President Kennedy has stressed the need for future research, but one may reasonably ask if planning is not going far in advance of any actual knowledge. Grad and Sainsbury (3) have shown that families expected to share the burden of caring for patients rather than having them admitted to hospital tend to assume greater burdens, and this can be demonstrated in the diminished wage-earning capacity of the family members. So far, they have been able to demonstrate no significant effect on the children of families who have mental patients being treated at home, but it is too soon to have any findings on the long-term effect on children under such circumstances.

In conclusion I would like to say that it seems to me that there are fascinating similarities in the current state of psychiatry in Britain and America (6). Both seem determined to develop

community services with a view to using the social environment, where possible, rather than the mental hospital setting. The flight from the mental hospital in Britain is much less evident than in America, and this may be partly due to the obvious advantages which the British hospitals have with regard to size and relationship to the communities which they serve. Nevertheless, it would seem that President Kennedy's (or, more correctly, his psychiatric advisers') message does a grave disservice to the existing mental hospital services, which, if developed along therapeutic community lines, could serve as an essential part of the training of psychiatrists or the new community psychiatry which is being envisaged. The surprising vitality shown by many hospitals in developing along lines of decentralization with small units serving discrete geographical areas (2) receives no mention in the President's message to Congress, nor is it clear where the training of psychiatrists and other personnel to serve in the mental health clinics is to be carried out. I in no way wish to imply that I have any doubts about the ultimate success of the clinics which have developed along rational and democratic lines, such as the Fort Logan Mental Health Center. I would imagine, however, that the people at Fort Logan are most circumspect about the disappearance of a state hospital such as their neighbor at Pueblo State Hospital. There seems to be much to learn from both developments, and my own feeling is that to predict sweeping changes at the present stage of our knowledge is to demoralize the very people who have carried the major burdens of mental illness in the past.

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PATIENT ATTITUDES TOWARD STAFF ROLES*

LESLIE JORDAN**
Fort Logan Mental Health Center, Denver, Colorado

At Fort Logan Mental Health Center staff members extend their functions beyond those normally expected of their respective professions: nurses attend therapy groups and write social histories, as well as dispense medication; psychiatrists and psychologists go on picnics and work in occupational therapy with the patients. If the patients come to view the nurses and technicians, as well as the psychiatrists, as their therapists, the number of therapists in the therapeutic community is increased. In order for this goal to be achieved, expansion of functions must result in expansion of roles. A function is a job to be performed by a person; a role is the part he is playing for other people, and depends on the expectations and values other people attach to him. It would be quite possible for a psychiatrist to be performing the functions of a technician and still to be viewed by the patients in the role of the doctor. This paper will examine a pilot study which was undertaken to ascertain the effectiveness of the expansion of functions in creating an expansion of roles.

An interview, containing twenty-one questions, divided into nine sections, was administered informally to the patients in the day room or quiet room of the cottage. If a question was not understood by a patient, it was put in a different way by the interviewer until it was clear. Each interview lasted about twenty-five minutes. The questions were aimed toward finding out which staff members were considered by the patients to be playing therapeutic roles. Thirty patients were chosen at random to be interviewed. Ten

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patients--five 24-hour patients and five day patients--were inter-
viewed from each psychiatric team. The only criteria for choosing
patients were that they were participating in the hospital program
at least two days a week, and that they had been a part of the pro-
gram for at least a month. Except for four patients who preferred
not to be interviewed, the patients were very cooperative and will-
ing to supply all the information requested.

THE INTERVIEW

The patients' answers to the questions are presented in
Table 1 and Table 2.

TABLE 1*

RESULTS OF ROLE INTERVIEW

QUESTIONS	ANSWERS							
	MD	PS	SW	RN	TK	T	P	N
I. RESPONSIBILITY								
1. "Who decides when you will leave the hospital?"	23	0	0	1	0	5	1	0
2. "What if you left the hospital against advice--who would decide how to handle it?".	18	0	0	2	0	6	1	0
3. "What if you refused to go to lunch a few days in a row--who would decide how to handle it?"	8	0	0	4	0	11	2	0
4. "If you think the patients are treated differently, who do you think makes the decisions as to how each patient will be treated?".	8	0	0	1	0	6	0	0
II. EASE OF COMMUNICATION								
5. "When you have a problem, whom are you most likely to go to about it?"	12	1	6	7	2	3	0	1
6. "Who is it easiest for you to talk to about your problems?".	8	1	5	8	2	6	0	2

TABLE 1 *(continued)*

RESULTS OF ROLE INTERVIEW

QUESTIONS	ANSWERS							
	MD	PS	SW	RN	TK	T	P	N
7. "Who do you feel is most willing to help you?"	2	1	3	4	3	13	0	2
8. "With whom is it easiest to express your most intimate thoughts in the area you find hardest to talk about?".	9	2	4	3	2	1	0	2
III. UNDERSTANDING OF PROBLEMS								
9. "Who knows the most about what is happening to you, and what your problems are from day to day?".	7	1	4	9	5	9	0	0
10. "Who knows the most about the problems that brought you to this hospital?".	18	2	7	1	0	2	0	4
11. "Who is the most capable of understanding when you talk to him about your problems?".	11	3	6	6	5	5	0	1
IV. PROFESSIONAL SKILL								
12. "Who is trained best to help you?". .	22	2	2	3	1	3	0	0
V. CONCERN ABOUT PATIENTS								
13. "Who cares most about what happens to you?".	5	0	2	5	2	12	0	3
VI. DEDICATION								
14. "Who is most devoted to doing his job well; who works hardest?".	11	0	5	4	3	10	0	1
VII. AVAILABILITY								
15 "Which staff member(s) do you spend the most time with?".	2	0	3	13	8	6	0	2
16. "Who do you talk with most often about your problems?".	7	1	7	8	3	5	0	6
17. "Who is most often available to talk with about problems?".	1	1	2	14	11	5	0	0

TABLE 1 *(continued)*

RESULTS OF ROLE INTERVIEW

QUESTIONS	ANSWERS							
	MD	PS	SW	RN	TK	T	P	N
VIII. VALUABLE HELP								
18. "Who has helped you most since you have been here?".	6	1	5	7	3	10	0	2
19. "Who has most often given you valuable support or advice?".	7	3	7	9	6	2	0	3
20. "Who has helped you most to develop insight into your problems?".	8	6	4	1	2	2	0	7
IX. DIFFICULTY IN COMMUNICATION								
21. "Which professional group have you found it hardest to talk with about your problems?".	3	0	3	4	6	0	0	15

*The number of patients giving each answer is below the designation of each possible answer. Because many patients mentioned two people as being equally valuable, the total number of answers often exceeds the number of patients interviewed. "MD" stands for psychiatrist, "PS" for psychologist, "SW" for social worker, "RN" for nurse, "TK" for technician, "T" for entire team, "P" for patient, and "N" for nobody. A team consists of one psychiatrist, one psychologist, two social workers, seven nurses, and six psychiatric technicians.

On one team the psychologist was acting as the head of the team. Nine of the ten people interviewed on this team stated that he was a psychiatrist, and the tenth was not sure whether he was a psychiatrist or a psychologist. Since he was acting as head of the team and considered by the patients to be a psychiatrist, I have included him as "MD," or psychiatrist.

At the time this study was performed, no psychiatric technician had had more than six months of experience in his job.

When the responses to the separate questions within each section are totaled, the results indicated in Table 2 are obtained.

TABLE 2

COMPARISON OF TOTALS OF ANSWERS IN EACH SECTION

INTERVIEW SECTIONS	ANSWERS							
	MD	PS	SW	RN	TK	T	P	N
Responsibility	57	0	0	8	0	28	4	0
Ease of Communication	31	5	18	22	9	23	0	7
Understanding of Problems	36	6	17	16	10	16	0	5
Professional Skill.	22	2	2	3	1	3	0	0
Concern about Patients	5	0	2	5	2	12	0	3
Dedication	11	0	5	4	3	10	0	1
Availability.	10	2	12	35	22	16	0	8
Valuable Help	21	10	16	17	11	14	0	12
Difficulty In Communication	3	0	3	4	6	0	0	15

DISCUSSION OF INTERVIEW RESULTS

Section I. Responsibility

Most of the patients saw the doctor on the team as having the responsibility of making decisions. As the decisions became less important, the responsibility was seen by more patients to fall on the nurses or on the entire team. Only a few patients felt that they themselves played an important part in making decisions.

Section II. Ease of Communication

In this section a significant number of patients answered "nobody" to some of the questions. This answer was also given

in other sections, but not by the same people each time. Some of
the reasons for answering "nobody" in this section were: prefer-
ring to speak to other patients rather than staff members, finding
difficulty in talking to anyone, feeling the staff members were not
really willing to help, and having private psychiatrists elsewhere
with whom they could communicate easily.

"The doctor" was given as the most frequent answer in this
section, with the nurses and social workers mentioned next most
often. Very few patients named the technicians as a group to which
they would take problems.

The doctor was described as a passive listener, but as the
"only one who can do anything." The nurses were described as
more responsive and friendly. The technicians, who were felt to
be unqualified due to lack of training, were also described as more
responsive and sympathetic than the doctor. The social workers
were described by some of the patients as "less well educated"
than the doctor, but as having "more wisdom." They were felt to
be not as passive as the doctor and not as responsive as the tech-
nicians and nurses. Fellow patients were described as being the
most responsive of all.

The patients identified a more passive attitude with knowing
more, and knowing more with being more trained. Hence, there
appeared to be a dichotomy for them between knowing more and
being easier to talk to. The more training a staff member had had,
the more he was described as a silent, but perceptive, listener, and
not as a friend and adviser. The totals of the answers in this
section possibly reflect the view that it is more important to talk
to someone who knows than someone who cares.

When the patients are asked who was most willing to help
(question 7), the doctor and the psychologist were mentioned less
often than the social workers, nurses, and technicians.

Section III. Understanding of Problems

Of the patients who answered "nobody" to questions 10 and
11, three said their private psychiatrists were the only ones who
knew their problems, and one patient said she never talked about
her problems with anyone.

The largest number of patients felt that either a nurse or the
entire team knew most about their day-to-day problems. When

asked who knew most about the reasons for their problems, eleven patients answered, "The people who were present at my evaluation interview." In most cases this was the doctor and a social worker or a psychologist. These patients felt much more comfortable approaching someone with whom they had already talked about their problems, because they felt they were the only ones who knew what the problems were. Other patients mentioned members of their small therapy group as the staff members who knew their problems best. Many of the patients actively tried to avoid taking a step forward to talk over their problems; they preferred to be approached. The technicians were described as being quite passive in approaching patients, although, as seen in Section II, they were considered to be very responsive in discussing problems with patients. The nurses were considered less passive in approaching patients.

Section IV. Professional Skill

The doctor was again chosen by most of the patients. The people who felt that the social workers were best trained to help explained that it was because their problems were all financial. The man who mentioned the technicians as the best trained said a technician was valuable by reason of his lack of training, which put him on the "patient's level."

Section V. Concern about Patients

The most common answer to this question was, "I don't know. I guess everyone cares about the same." The three who answered "nobody" felt that the staff were indifferent to what happened to the patients, and taking care of patients was just a job.

Section VI. Dedication

The largest number of answers in this section were about evenly split between the doctor and the entire team.

Section VII. Availability

The technicians and nurses, the staff members with whom the patients spend most time, were seen as most often available to talk

about problems.   The doctor, psychologist, and social workers were considered less available. Yet, despite the unavailability of the social workers and the doctor, the patients considered them as the most important people to seek out. Despite the availability of the technicians, very few patients sought them out for discussion. The nurses were the only ones whose availability/demand ratio was consistent. From these results it appears that one purpose of the blurring of functions, the patients seeking out the technicians, as well as the doctor, for therapy, was not being carried out. The patients were not taking advantage of their closest staff companions as therapists.

Section VIII. Valuable Help

Most patients seemed to feel that being helped at the hospital depended on what several people called a "group effort."   The answers to the question of who most frequently gave valuable support or advice were fairly evenly distributed among the staff members, with the nurses being mentioned slightly more frequently. Credit for insight came back to rest on the doctor and psychologist. The nurses and technicians were seen as contributing very little to the development of insight. Those who gave "nobody" answers stated that they had not developed any insight.

Section IX. Difficulty in Communication

The most common response was that no one was hard to talk to.   Of the staff members, the technicians were mentioned somewhat more frequently than the others.

COMPARISON OF TEAMS

Answers to all questions were recorded first on a team-by-team basis, and within the teams were divided into day hospital and 24-hour-patient sections.   There was no significant difference between the responses of the day hospital and the 24-hour patients on a given team.

With a few exceptions, there were no significant differences between the teams either. The first exception, while not especially

significant in itself, is mentioned in order to clarify the results. Since the psychologist on Team A was seen by the patients to be playing the role of a psychiatrist, the psychologist was not mentioned in the responses of the patients interviewed on this team. On Team B, in which the psychologist only worked half-time on the team, the psychologist was again not mentioned. Every mention of the psychologist was made by patients on Team C. So, even though the total number of votes for the psychologist appears to be small, it must be remembered that every mention of the psychologist was from only one team. For that one team, the number of times the psychologist was mentioned was quite high, especially on question 20, when six out of ten people interviewed said the psychologist had been the most helpful staff member in developing insight.

The second exception is more significant for the study. The number of times the "entire team" was given as the answer was analyzed on a team-by-team basis. The results are shown in Table 3.

TABLE 3

COMPARISON BY TEAMS OF FREQUENCY OF "ENTIRE TEAM" ANSWER

TEAM	NUMBER OF "T" ANSWERS
Team A	44
Team B	47
Team C	19

The number of times the patients on Team A and Team B mentioned the entire team in response to a question is almost identical. On Team C this answer came up less than half as often. Team C has the reputation of being more structured than the other two teams; there is supposedly less expansion of functions on this team. It is one of the goals of expansion of functions to make everyone more therapeutically equal in the eyes of the patient. This is essentially what the "entire team" vote means: the patient considers everyone on the team equally capable of performing

whatever function is in question, and thus fitting into whatever
role the function implies. Thus, the number of "entire team"
answers could be considered a guide to the success of creating an
expansion of roles on the team. If the lower number of "entire
team" answers on Team C resulted from a lower degree of ex-
pansion of functions, then expansion of functions can create
expansion of roles.

CONCLUSION

Despite the program of expanded functions at Fort Logan
Mental Health Center, the psychiatrist is still the center of the
patient's therapeutic world. The technicians are not considered by
the patients to be equal to the other staff members on the team. In
fact, none of the staff is playing "equal roles" from the patient's
point of view. Some are considered more therapeutically valuable
than others. The technician, especially, is not greatly valued as
a therapist by the patients. However, there is some reason to
speculate, by reason of the large number of "entire team" votes,
that expansion of function has produced some slight blurring of
roles in the eyes of the patients interviewed in this study.

THE FORT LOGAN MENTAL HEALTH CENTER: GENESIS AND DEVELOPMENT

ETHEL M. BONN, M.D.,* *Clinical Director*
and ALAN M. KRAFT, M.D., *Director*
Fort Logan Mental Health Center, Denver, Colorado

Mental health and mental illness potentials coexist in every person. To define which may predominate in a given individual at a given time has been the core issue of much debate--diagnostic and therapeutic, psychological and social, medical and legal. That mental health may supervene--given the necessary conditions--in the overwhelming majority of those who suffer from mental illness, is the key premise upon which the Fort Logan Mental Health Center' Center was founded.

SOCIAL AND ECONOMIC ASPECTS

The gigantic social and economic problems created by the major mental illnesses (the psychoses) have troubled many people, both professional workers and the lay public. It is indeed disturbing to realize that one-half of all hospital beds in the United States contain patients with mental illness. For taxpayers, it is also disturbing to note that, of these beds, 92.4% are financed by public funds (state and federal) and 7.6% by private payment (2). The high cost of mental illness in both personal and economic terms is unquestionable.

As the President said in his recent message to the Congress on mental illness and mental retardation (7), public financing must

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*Box 188, Fort Logan, Colorado.

underwrite nearly the entire cost of major mental illness. The fuller development of mental health insurance and private payment plans will help defray the cost to the public, but much more remains to be done.

In Colorado, the cost of mental illness had been compounded by having one overburdened facility at the Colorado State Hospital in Pueblo, where overcrowding and long-term stays were then inevitable. To improve this situation, a new state hospital, the second founded in Colorado, came into being in 1961. This hospital, the Fort Logan Mental Health Center, is a part of Colorado's program for solving increasing problems in mental health. Now the Fort Logan Mental Health Center is serving one-half of the state's population (the Denver area, 900,000 people), while the Colorado State Hospital serves the remainder of the state.

In the recent report (1961) of the Joint Commission on Mental Illness and Health (1), there is clear, comprehensive evidence that psychiatry needs more effective methods, especially in hospital treatment of patients. At many centers, a variety of successful treatment methods are being used. The Fort Logan Mental Health Center has borrowed, modified and integrated some of these methods into a comprehensive psychiatric program. Our center is, we think, a model for the treatment of a maximum number of patients, with a minimum number of beds and, by some standards of comparison, with a surprisingly small number of clinical staff (eighteen staff members per team, per one hundred patients).

Too often there is a wide gap between advances in psychiatric knowledge and the psychiatric treatment in practice. In order to provide ongoing evaluation of results, the Fort Logan Mental Health Center program was designed to include a continuing self-scrutinizing research project as an integral part of its total operation. This project, using IBM equipment to process many variables in our patients, including clinical failures and follow-up care, has been underway since July, 1961, when the first patients were admitted.

How does the Fort Logan Mental Health Center prevent crowding and minimize length of hospitalization and thus cut down on the high cost of mental illness? A crucial part of our program is preadmission evaluation. We recognize the time-honored indications for round-the-clock hospitalization: (a) the patient is danger-

ous to himself and (b) the patient's environment can no longer tolerate him. In order to care for the large numbers of patients who do not fit these criteria, we employ many alternatives to full-time care. All patients, whatever their recommended 'treatment, are encouraged to make full use of their assets while getting help for their liabilities. We have relatively few patients in 24-hour care, but we have many, many patients in day hospital and some in evening hospital, halfway house, family care, and out-patient care. (For precise figures, please see the statistical table on page 26.) Put another way, we titrate our direct assistance against the patient's need for external support.

GENERAL PHILOSOPHY

Our center--in both its divisions--is entirely open. We employ psychological, social, chemical and somatic therapies--without physical restraints. We manage disturbed behavior by means other than the lock and key.

RATIONALE FOR TREATMENT

Psychiatry has long recognized that a bed does not cure a mental illness. Rather, help for the mentally ill person comes from people. For a long time, it has been a widely held view that individual, one-therapist-to-one-patient treatment is the most effective means of intervening in a mental illness. For a large number of patients this is undoubtedly true, and may always be so.

But for the majority of mental patients, such individual psychotherapeutic treatment is not only impractical, because of the lack of individual therapists, but also ineffective, for reasons intrinsic to individual psychotherapy itself. Some of the factors accounting for this are: (a) the relative inaccessibility of such patients to classical, verbal dyadic techniques, (b) their relative intolerance for intensive, dyadic relationships, and (c) their greater susceptibility to influence by nonverbal, action-oriented, social or environmental forces. Such patients are better able to integrate experiences in a group setting, where relationships are less intense

and more comfortable, where the chances of learning by observing others are multiplied, and where social pressures to conform to nondeviant behavior can be very strong, often sensitively timed, and more acceptable because they come from peers, as well as from staff. At the Fort Logan Mental Health Center, for these reasons, we use group psychotherapy and therapeutic milieu techniques extensively, with all patients and staff participating in the group therapy sessions and therapeutic living interactions.

Participating in payment for treatment is a well-recognized factor motivating the patient toward energetic involvement in the recovery process. At the Fort Logan Mental Health Center, we use a sliding scale of fees for our patients. The average cost per day of inpatient care is $20.00, for day patient care is $8.00, and for outpatient follow-up care is $8.00 per week.

THE PSYCHIATRIC TEAM

The psychiatric team, consisting of a psychiatrist (team leader), two social workers, a psychologist, seven nurses, and seven mental health technicians, treats the patients (exclusive of children, seniles and alcoholics) who come from a specified geographic area. The team has fourteen to fifteen beds available for 24-hour patients, ten halfway house places, ten family care places, thirty-five day patient places and thirty follow-up care places. On the basis of its clinical judgment, the team admits, transfers and discharges patients to and from any of these transitional modalities. We have two cottages and four units (wards) in a two-story pavilion; each of these six units houses two teams. Our buildings are tastefully furnished in styles appropriate to our patients' socio-economic backgrounds; we employ simple, contemporary, but not "arty," designs and colors.

We capitalize upon the therapeutic advantages of community-based operations. All of our patients come from the Denver area. Each psychiatric team is assigned a specific area from which it receives patients. With this arrangement, the team can learn much from and about the family, the employer, the minister, the family doctor, the local courts and law-enforcement agencies, etc., in its own geographic area. Should the patient return to the hospital, he

returns to the same team. This arrangement facilitates his utiliz-
ing previously developed relationships as well as new ones with
team members more effectively, thus enhancing his therapeutic
opportunities.

ORGANIZATION OF TEAMS AND HOSPITAL

Our team and hospital organization is designed to promote
reassumption of responsibility by the patient to whatever extent he
can, and to enlarge or decrease his area of responsibility as indi-
cated. Ordinarily, the organizational hierarchy of the state hospi-
tal has maximum authority vested at the top, and relatively little
delegated to the lower echelons. Because the latter (the nursing
staff, in particular) must often make decisions and act promptly
in the course of their everyday duties, these staff members, in such
a traditional institution, must assume authority and responsibility
quietly, usually covertly, and frequently antitherapeutically. This
can work to the detriment of the patients and to the demoralization
and stagnation of the staff, at all levels.

At the Fort Logan Mental Health Center, we have decentral-
ized authority and delegated primary responsibility to the treatment
teams. The patients are a part of each team. Each patient is
encouraged to accept whatever responsibility he can--however
small, however great--and to turn to another person whom he knows
and trusts for help when he has reached the limit of his own re-
sources. Thus he may turn to another patient, to a mental health
technician, to a nurse, a psychologist, a social worker, or to a
psychiatrist. This process allows for problem-solving and social
learning at the time and in the place where the problem occurs, in
the here-and-now--not at some future time, scheduled or indefinite.
Therapeutic value is enhanced by the immediacy of the process.
For the seriously restricted ego, such immediacy frequently is of
more value than the process in a dyadic relationship. In the latter,
insight is more often the means of experiential learning rather than
problem-solving, which is left to the patient to work out in the
extra-therapeutic situation. In our therapeutic community where
problem-solving for experiential learning is offered, our Patient
Government is an active organization affirming our approach.

Thus when the patient reaches an impasse, however minor or great, he learns to consult with someone--patient or staff member-- on the team. Eventually, the team leader may consult the clinical director and the clinical department heads for advice, counsel and assistance. The functions of the clinical director and the clinical department heads are to encourage and guide, rather than to hamper by overvigilance or overrestriction the team's initiative, creativity, and therapeutic inventiveness. Figure 1 illustrates the process
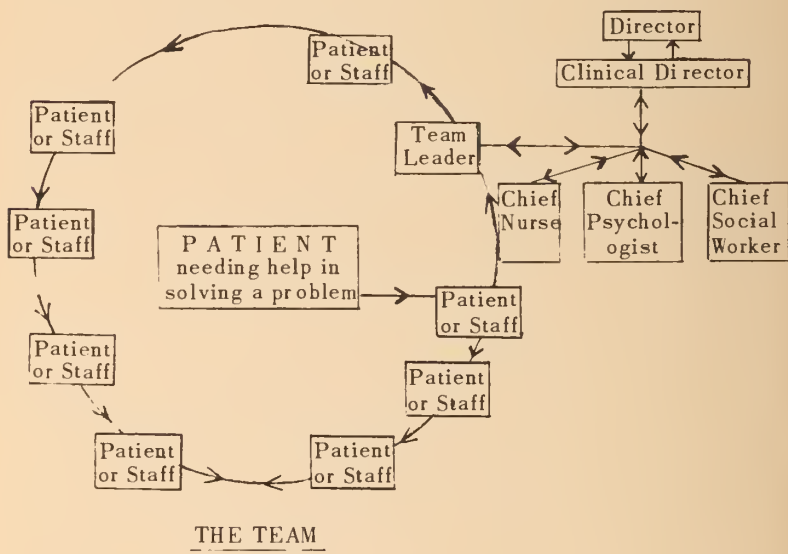

Figure 1. Flow of initiative in problem-solving on the psychiatric team.

IDENTITIES AND ROLES OF STAFF AND PATIENTS

How do our staff give optimum help to such a large number of patients? We do this by expanding the roles of staff members to capitalize on each person's functioning skills and assets. Each staff person contributes what he can, not what is prescribed out of some stereotyped, preconceived dogma of roles. The *summum*

bonum of each person's contribution is from the *self*, not from his training alone. This aspect of each person's contribution is underscored by our not wearing uniforms of any kind. The contribution of the self is shaped and guided, we feel, by a person's training, whatever it may be. Formalized background is allowed to blend inseparably with the personal background, each mutually supporting the other to make the full-functioning team member.

Clearly the significance of the professional training and background must be reconciled with the evolving role of each team member. In our past experience in other settings, it was far easier to let the phantasm of professional training interfere with team functioning, than it was to utilize professional training properly. In this setting, the professional images of the doctor, the nurse, the psychologist, and the social worker still have a charismatic, as well as a rational-legal and traditional authority, far outweighing that of the mental health technician. However, unlike that in many hospitals, our nurse/mental health technician staffing ratio is one to one. *To the mental health technicians and nurses, the bulk of the responsibility for direct patient care must be given, and it is from them that the patient receives much of his help.*

Obviously, it is imperative that the professionally trained staff share their knowledge, skills and responsibility effectively with the mental health technicians. The technicians have an advantage in that they are not burdened with the rigidity or *status-consciousness* which so often stems from the extensive professional training of some of their team colleagues. On the other hand, the technicians, and to varying degrees, members of other disciplines, have an inverted form of status-consciousness born of feelings of inferiority which interfere with their success in collaborating with psychiatrists and in working with patients productively. The psychiatrist, in particular, must make special effort to allow the mental health technicians and all other team members to share their knowledge of patients effectively with the entire team. By stressing the value of open communications and by being alert to phenomena symptomatic of blockades to communications, we at the Fort Logan Mental Health Center have tried to create a therapeutic climate.

The patient is encouraged to identify himself as a patient, as a member of the team and as a part of the Fort Logan Mental Health

Center *and* a functioning citizen of his own community. He is further encouraged to disassociate himself from his illness and to ally himself with the healthy, normal, nondeviant world. This process is enhanced by our having the 24-hour patients participate in the same daily treatment program side by side with the day patients and those in other programs. Also important to the process is our practice of including relatives of almost all our patients in the treatment program (in family groups and in frequent informal contacts).

THE COMMUNITY

Our hospital's relationship with the community supports our program of helping the patient develop a realistic self-concept. One aid to community awareness on the part of our staff and our patients is our growing volunteer program. We see our volunteers as easily identified representatives of the outside community in the treatment program, as well as in non-patient programs (e.g., raising money for our chapel). We encourage tours and visits by people from the community. We help our patients to obtain employment in the community.

To intensify the patient's investment in the community in other ways, we have tried to avoid the mistake of becoming self-sufficient as an institution. In several areas we have deliberately developed the hospital's dependence on the community. Day patients depend on public transportation and car pools to come to the center, rather than transportation supplied by the hospital. We do not have a patient library, but do have a few copies of books in each living area; we urge our patients to use public library facilities. We do not have a commissary or department-store-like facility; we encourage our patients to use local stores. We do not have laundry and dry cleaning facilities; our patients and staff use those of their choice in the community. We do not have a swimming pool or bowling alleys; we use those in the community. We do not cut off our patients' lines of communication to and from the hospital; we permit and actively encourage our patients to write letters and to use the telephone, freely. We do not schedule visiting hours; we work supportively with the patient and his relatives toward making visiting as convenient and therapeutic as possible.

THEORETICAL FRAMEWORK

Our psychiatric program is based primarily on the principles of the therapeutic community. We have borrowed heavily from Maxwell Jones (4, 5, 6), the Cummings (2), and others in developing our program. Because many of our staff have had psychoanalytically oriented training, we have had the advantage of integrating the psychoanalytic concepts and models into our transactional thinking. By and large, we utilize psychoanalytic concapts diagnostically and to a certain extent therapeutically in the rationale of our activities therapies. (Menninger (8) and Simmel (9)) Generally, our treatment programs develop social skills and interpersonal relationships which, in turn, seem to influence intrapsychic processes (rather than the reverse procedure).

ALCOHOLISM PROGRAM

Our Alcoholism Team consists of the team leader (a pastoral psychologist), six nurses, seven aides, one psychiatrist (who evaluates patients psychiatrically and acts as a consultant to the team), two internists (who evaluate patients physically and serve as consultants to the team), two halfway house parents, and two social workers.

Our alcoholism program is divided into two phases. Phase One is a five-day inpatient evaluation program, consisting of a physical and a psychological examination and a series of exhortative lectures designed to inform the patient of the physical, psychological, and social consequences of chronic alcoholism. At the end of this phase, the patient is given the choice of continuing in treatment by agreeing to enter Phase Two, or of leaving the program. If he leaves, the patient may not return for one year. About 80% of the patients elect to enter Phase Two, which consists of one week of day hospital followed by outpatient group therapy three times a week. Of these patients about 50 to 60% have maintained sobriety for a year. We view these figures with the caution born of long acquaintance with the vicissitudes of alcoholism. Nevertheless, by assuming that a patient can be helped to maintain sobriety but will always be a potential drinker,

we have supported a large number of patients. (We recognize that 10% of alcoholics (3) may not be in the "once an alcoholic, always an alcoholic" category--but for communication purposes, we have simplified our approach--with the above encouraging results.)

STATISTICS

The first patient was admitted July 17, 1961. During its first eighteen months of operation, the center had 1,193 first admissions and 119 readmissions. Nine hundred and twelve patients were discharged. There were twenty-four beds in the Alcoholism Division and eighty-four beds in the Psychiatric Division.

On July 31, 1963, there were 399 patients in the Psychiatric Division, distributed as follows:

24-Hour	69
Day Hospital	173
Night Hospital	20
Halfway House	6
Follow-up	93
Family Care	38

On July 31, 1963, there were 306 patients in the Alcoholism Division, distributed as follows:

Phase I	16
Phase II	290

PLANS FOR THE FUTURE

Expanding in stages, we will ultimately have a facility of 400 beds, treating 2,500 patients at any given time. The seven psychiatric teams will grow to a total of fourteen. The Alcoholism Team will continue. There will be a separate medical-surgical unit, a geriatric unit, an adolescent unit, and a children's unit.

In our opinion, we have a mental health center adoptable in many ways as a model for public mental health centers in many

other settings. We are very proud to be a part of this hopeful approach to the treatment of the major mental illnesses.

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TREATMENT PROGRAM OF THE ADAMS COUNTY TEAM*

BERNARDO GAVIRIA, M.D.,** *Staff Psychiatrist*
Fort Logan Mental Health Center, Denver, Colorado

INTRODUCTION

The Adams County Team is one of the psychiatric treatment units at the Fort Logan Mental Health Center. It has been in operation since July, 1961. The treatment program, as well as the general structure of the team, has undergone many changes. Many other modifications are likely to take place in the future, and we also expect to achieve a better definition of the different elements of the program and their rationale.

The treatment program, as we see it now, is one of the possible versions of the therapeutic community, which is, in turn, the basic approach of the Fort Logan Mental Health Center (1). Although many· parts of the operation are provisional, and to a large extent experimental, the whole approach of the Adams Team to treatment is based on a few general ideas, which can be roughly defined as follows:

1. Most of our patients have come to the hospital because of "sick" behavior, that is, gross inadequacy in their relationships with other people and in their everyday life decisions.

2. The best way to help patients in these "problems of living" is to offer them situations where they can learn new and better solutions. Those situations should resemble life outside the hospital. However, to make them therapeutic they should be deliberately set up in such a way that the patient will have a better opportunity for examining, discussing, understanding and experi-

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menting than he has had in similar situations outside the thera-
peutic community.

3. Most of the patients retain, more or less intact, many areas
of their personalities. We feel that they are capable of setting
goals, of making decisions, of assuming responsibilities, and of
learning new patterns of behavior. Positive motivation for treat-
ment is very important, and we proceed on the assumption that to
achieve the goals of treatment the patient must want to change his
behavior.

Using these broad ideas as a basis for the program, we have
structured it around the following general guidelines:

1. Voluntary hospitalization is encouraged. In most cases it
is necessary that the patient be free to make the decision of ac-
cepting treatment. This, however, does not imply complete agree-
ment with every step of the program. The patient should partici-
pate in it as it is offered, and not exclusively as he would like to
have it. The patients are urged to express their opinions, to venti-
late their feelings, and to offer their suggestions about the program,
but they are not expected to refuse participation in those parts of
the program that the staff considers essential to the therapeutic
plan. If a patient is using the hospital for a purpose other than
treatment, we try to find a different solution to his problem, whether
by transfer to a nonintensive setting such as family care or by
discharge and appropriate referral to another agency or institution.

2. All patients are exposed to several different group situa-
tions. These situations are therapeutic groups serving different
levels of development and function. We feel that integration and
adjustment to the group are basic to the solution of interpersonal
problems and, therefore, goals common to practically all patients.
In the operation of each group the staff participates as much as it
is possible and desirable.

3. Important as group adjustment is, we feel that individual
contact with staff or with other patients is extremely valuable in
the improvement of behavior. One-to-one relationships are en-
couraged, in connection with and within the context of the group.

4. We feel that the development of the patients' own initiative
and self-confidence is as important as learning to use adequately
the program prescribed by the professional staff. Therefore, a
large part of the program is reserved for activities initiated and

carried out by the patients.   In this area the staff helps in an
advisory capacity, seeking to avoid the formulation or the respon-
sibility for the execution of the patients' plans.

5.   There has been a definite trend at Fort Logan toward an
extensive "blurring" of roles.   Staff members may have the same
duties, make the same decisions, assume similar responsibilities,
and, in general, function interchangeably within the team, regard-
less of their professional group and, to a large extent, of their
background.   In our team this "blurring" of roles is deemphasized.
A clear distribution of the lines of responsibility, when possible
according to the skills proper to each discipline, has proven more
satisfactory to the staff and does not seem to be any less effective
in the operation of a therapeutic community.   Although there is
considerable expansion and overlapping in the functions of the
different disciplines, there has been a definite effort to promote a
certain degree of specialization according to disciplines or to
individual talent or inclination.

THERAPEUTIC ACTIVITIES

The therapeutic activities can be grouped within the following
classes:

A. Group Therapies.   Practically all patients attend four
types of groups: psychotherapy, occupational therapy,
recreational therapy, and community and self-government
groups.

1. Group Psychotherapy.   In our team this is conducted in
small groups, each consisting of four to eight patients
and two (occasionally three) therapists, often with the
addition of one observer (usually a student nurse or a
social work student).   The number of groups, as well
as their composition, may vary according to different
circumstances.   At present there are six groups, and the
assignment of patients is made on a random basis,
except for the remotivational group, specifically de-
signed for severely regressed patients.   Staff partici-
pation is voluntary.   The groups meet twice a week for
sessions of one hour.   Each group is relatively autono-

mous, being conducted in the way the therapists con-
sider to be the best. Many patients also participate,
with their immediate relatives, in the patient-family
groups, which take place once a week in the evening.
These family groups, conducted in a manner similar to
the patient groups, are developed and coordinated by
the team head social worker. Nonteam members of the
Departments of Nursing, Psychology and Social Service
have been active in the group psychotherapy program
as therapists and consultants.

2. Occupational Therapy. Three mornings a week all
patients attend group occupational therapy. The team
(patients and staff) is divided into interest groups
(sewing, woodwork, ceramics, art, leather craft, etc.),
each working on a project, or a part of a project, for
the team, the cottage or the hospital. Although it
tries to utilize individual talents and skills, each
group aims at developing satisfactory interaction and
ease in the relationships among members. The coordi-
nator of the occupational therapy program is the team
psychologist.

3. Recreational Therapy. The responsibility for planning
and carrying out the programs for the different recre-
ational groups goes to three members of the nursing
staff. Two mornings every week are spent by the pa-
tients in recreational therapy. Frequently the program
utilizes the hospital-wide available activities like
square dancing, bowling and swimming. As often as
possible the activities are directed at teaching social
skills and improving the social performance of the
patients.

4. Community and Self-government Groups. Activities
that involve self-government and the development of a
system of authority and organization among the patients
are encouraged. The staff tries to cooperate not only
in an advisory capacity, but also in accepting the
authority of patients in decisions involving everyday
life problems, like the use of privileges or restrictions,
the use of funds raised by special projects, and the

solution of conflicts among groups of patients.   The patients are also in charge of the general cleaning and everyday maintenance of the building.   Specialized tasks, however, are carried out by the maintenance division of the hospital.   The patients have a team advisory council, and elect representatives and officers to the cottage council (each cottage houses two teams) and to the hospital-wide Patient Government and its committees such as activities, employment, and patient welfare.

Evening patients, like inpatients and day patients, participate in the first three types of groups. They do not, however, participate in the housekeeping and self-government activities.

B. Non-group Therapies.

1. Individual psychotherapy with members of the team staff has been used in a few cases where it seemed to offer some specific advantage.   Individual occupational and recreational projects are optional activities, in which, as in other community work, the patients can engage, on a voluntary basis and during their free time.

2. Work assignments are given often, usually as adjuvants to the group therapies, or in some cases only for some immediate goal.   In cooperation with the Industrial Therapy Department some patients work for variable amounts of time at hospital departments such as switchboard, kitchen, beauty parlor and supply.

3. Drugs, especially tranquilizers and antidepressants, are utilized frequently and extensively.   Of the other somatic therapies, electroconvulsive therapy has been used to a very limited extent.

The range of optional group and non-group activities offered on a hospital-wide basis is very broad. The Adams Team also offers: (a) An open group discussion, held once a week. This is an unstructured meeting at which any subject can be brought up, and in which no immediate solution to a problem is usually sought. (b) Educational programs, once a week. An educational film is presented, followed by a free discussion about different subjects like general psychology, child development, mental health, drug

usage, and alcoholism. A Great Decisions group has also been meeting regularly and exchanging ideas about world news and international affairs. (c) Psychodrama is offered twice a week, once during the day program and once during the evening program. It is under the direction of the chief of industrial therapy, and has been utilized enthusiastically by the patients.

The program described covers the intensive treatment areas. Nonintensive programs include those involving the custodial care of patients who will not be able to live by themselves outside the hospital, as well as the follow-up of patients who do not need any further treatment in the hospital. The former are usually placed under the care of a family in the community, supervised jointly by the team staff and the hospital family care coordinator. For those patients who have been discharged, and who have gone back to the community, two of the nurses conduct an outpatient clinic. Outpatients go to the mental health clinic of their respective communities where they are seen individually or in groups, from one to four times a month. Follow-up of their progress is obtained and maintenance medication is controlled under supervision of the team leader.

COMMUNITY CONTACTS

According to the Fort Logan policy of geographic distribution, our patients come from the Adams County area, as well as a small part of Denver County. Our main contact with the different communities of Adams County is through the Adams County Mental Health Clinic at Adams City. In addition to the regular evaluation of prospective patients for Fort Logan, our staff holds periodic meetings with the staff of the clinic, and at present we are in the process of developing a program of information and education for the community. A marriage counseling group is conducted by social workers from the hospital team and the county clinic. The team psychologist has done consultation work with the county court, and is in the process of working out a series of educational workshops for different professional and civic groups. The team psychiatrist has served as a consultant to the community clinic on a request basis. The social workers have also done family therapy,

treating a whole family as a unit, on an outpatient basis. Closer cooperation with the visiting nurses of the Public Health Service is also being worked out, for follow-up and aftercare purposes.

PROGRAM EVALUATION

This is carried on continually by means of progress note meetings and team meetings. During the progress note meeting, each patient is invited to attend the staff discussion of his case, with emphasis on behavioral change and definition of goals for the future. The team meeting, held regularly, deals very often with the evaluation of the different procedures and programs, and with the consideration of changes and improvements. In addition to this, all members of the staff receive supervision and participate in the hospital educational activities. The team staff works also in the collection of clinical and statistical data which the Research Department processes and feeds back to the clinical staff, thus furnishing an on-going program evaluation. A special program of research, in which all psychiatric teams are involved, concerns itself with the evaluation of therapeutic success and failure, in terms of the Fort Logan basic philosophy and goals.

SUMMARY

The therapeutic program of one of the Fort Logan Mental Health Center psychiatric teams is presented. The general theoretical bases and guidelines are reviewed. The treatment program is considered one of the possible versions of the therapeutic community. The therapeutic activities, as well as the contacts with the community and the type of program evaluation used, are described.

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EXPERIENCE WITH SUPPORTIVE GROUP THERAPY WITH THE ADOLESCENT CHILDREN OF PSYCHIATRIC PATIENTS

KAY MC CARTHY, R.N.,* *Staff Nurse*
Fort Logan Mental Health Center, Denver, Colorado

Increasing interest in recent years has focused on involving the family of the psychiatric patient in his treatment. Thus, Szurek (3) and, later, Otto Pollak (2) felt that both parents and, where necessary, other family members must be involved in concurrent therapy to ensure the success of the psychiatric treatment of children and adolescents. Ackermann (1), carrying the process one step further, has repeatedly urged that the family, rather than the individual patient, should be the focus of both diagnosis and treatment. In line with this thinking, psychiatric teams at Fort Logan Mental Health Center have attempted in a variety of ways to involve the patient in his treatment. This short paper will report our first seven months' experience with one such program, which offered supportive psychotherapy to the adolescent children of psychiatric patients.**

The adolescent group was formed to study and help with problems the group members might have around their parents' illness, to facilitate family communication, especially in relationship to treatment, and to find out more about the possible psychiatric needs of adolescents whose parents are undergoing severe mental illness. Membership was offered to twenty-four children in all, of which nine girls and six boys attended, with their parents' approval. Nine of the parents of these adolescents were diagnosed as schizophrenic, while six had the diagnosis of neurotic reaction.

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*850½ W. Lincoln Blvd., Freeport, Illinois.

The therapists of the group, two nurses and one psychiatric technician, were supervised by the chief of social work at the hospital. They saw their role primarily as providing stable, non-threatening figures with whom the adolescents could identify, and to whom they could turn for help. The group met once a week in the evening for one hour, which was later extended to one-and-a-half hours.

GROUP INTERACTION

The adolescents at first appeared anxious and apprehensive, and asked for a great deal of approval and acceptance, usually on a one-to-one basis. This was followed by an attitude of skepticism both about the ability of the therapists and the effectiveness of the meetings. By the third month, they developed a strong degree of group cohesiveness. They joked, often supported each other, and began to discuss meaningful and sometimes painful material. By the fifth month, their previously indirect hostility towards the therapists was expressed openly. This coincided with a period when their parents were showing extreme overt anger towards the staff in the hospital. During the sixth month, new members were added to the group. This resulted in anxiety, diminished group cohesiveness, increased flirtatious behavior, and renewed relating to the therapists on a one-to-one basis. Such disruptive periods in the evolution of the group often preceded the discussion of painful topics, and were followed by increased group cohesiveness.

PROBLEMS OF ADOLESCENTS
AROUND THEIR PARENTS' ILLNESS

Several of the group members felt that they had caused their parents' illness. These unrealistic feelings were increased when a child actually participated in the hospitalization of his parent, or when a parent on pass returned to the hospital because of a disturbed episode at home. The parents often participated in blaming their children for their problems. For example, on one occasion a

parent said to one of the adolescents of the group, "You're driving me crazy."

The members of the group indirectly expressed their concern about being ill like their parents. Their fears were intensified when one of them needed to be hospitalized for psychiatric illness. Another group member told of being accused by her paranoid schizophrenic mother of being ill, because she did not believe or understand her mother's delusions. Although the adolescents were not able to openly discuss the possibility of being ill themselves, particularly in the presence of the therapists, they attempted to gain support by asking each other how they appeared to the group and what the group thought of them.

There was a great deal of discussion about the adolescents' feelings of rejection by their parents. At times these feelings were attributed to the therapists, as well, in complaints on the part of the group members that the therapists did not really care about them. They expressed their desire to be taken care of by their parents, instead of having to take care of them. Many of them felt they had lost their parents' love. Some spoke of wanting to remove the pets from their homes, so that they would receive the love their parents were showering upon the animals. They felt that the lack of guidance and direction from their parents was an indication of their lack of importance to them. Some of the children were thinking of separating from their parents upon graduation from high school. This led to discussion of their conflicting feelings and guilt over deserting their parents, who would have no one to take care of them after the children left home.

Strong feelings of shame and resentment around their parents' inappropriate behavior in front of friends and neighbors was a source of painful embarrassment to the adolescent group. Many of them felt ashamed that they could not bring classmates home with them. School was another area of difficulty, and the schoolwork of some of the children was detrimentally affected by their parents' illness.

QUESTIONS OF ADOLESCENTS ABOUT TREATMENT

They often questioned the effectiveness of the treatment program for their parents, and particularly expressed angry feelings

about their parents receiving electroshock therapy. They asked whether the treatments were humane and could cure their parents, and spoke of their parents' loss of memory and loss of concern for recent events. They were shown the electroshock therapy equipment, and the procedure and expected results were explained to them. Two of the children were able to describe the beneficial results of electroshock therapy on their parents, but the others either described only the side effects, or were unable to tolerate discussing the effects of electroshock therapy on their parents at all.

Although the adolescents resented the added responsibilities they had in the home with one parent hospitalized, it appeared that they struggled more with their feelings about having their parents return home than with their feelings about having their parents hospitalized. Two of the children became extremely upset when discharge became imminent for their parents. In one case, the condition of a girl who had become schizophrenic and been hospitalized was exacerbated by the rapid improvement of her mother. In another case, a boy who had told his mother he refused to have her live with him threatened suicide twice when his family was approached about his mother's discharge. The adolescents worried about how they should behave towards their parents when they got home, and they worried about the possibility of relapse. At times, they were angry about their parents coming home and disturbing the peace of the household.

PATHOLOGY OF INDIVIDUAL GROUP MEMBERS

Three of the fifteen adolescents in the group presented inappropriate behavior and required more intensive psychiatric help. The therapists felt that three additional group members could have benefited from psychiatric help, but were able to function adequately without it. The remaining nine children did not present any inappropriate behavior and seemed to function well.

Jane was one of the group members with serious psychiatric problems. When her mother improved and was nearing discharge, she, like her mother, developed extreme muscular rigidities and was uncoordinated to the point of being unable to manipulate objects

or walk correctly. She revealed many ideas of grandeur and para-
noia. At the university psychiatric hospital to which she was
subsequently admitted, her diagnosis was paranoid schizophrenia.

Betty, Jane's older sister, appeared preoccupied in group
meetings and said very little. She walked rigidly like her mother
and sister and felt she was unable to use her right hand because of
a mythical accident to a finger. Although her symptoms were not
as severe as those of her mother or sister, it was felt that she
definitely needed further psychiatric treatment.

Bill twice made suicidal gestures when the time for his
mother's discharge approached, once with a knife, and another
time with a knotted necktie hidden under his pillow. He had pre-
viously told his mother to stop phoning him, since he was no longer
her son. For the three years prior to his being seen in group he
had experienced blackouts when he became extremely angry, during
which he isolated himself and became destructive, smashing ob-
jects nearby. Although initially he seemed rigid and without affect,
after three months in the group Bill became more relaxed and socia-
ble. He was encouraged to seek individual psychotherapy.

John, whose mother was hospitalized with paranoid schizo-
phrenia, had a tic of the right eye and mouth which became quite
severe when he talked. He continually played with his fingers,
slumped over the table, and looked at the table or his fingers when
talking. He spoke very slowly in a low voice which was difficult
to understand. After three months in the group, he became more
warm and aggressive in talking and socializing. His tic diminished
and he appeared to be less anxious.

SUMMARY

In summary, we feel that the adolescent group thus far has
been worthwhile. Although the therapists felt at first quite anxious
about running the type of group described because of their lack of
experience, adequate supervision and growing experience soon
made them feel more comfortable and effective. The adolescents
seemed to be able to derive a meaningful amount of support and
information from the therapists and from each other, and in several
cases the group successfully functioned in directing some of the

members to early intensive psychiatric help. Six of the fifteen adolescents needed, in the opinion of the therapists, further psychiatric help, and this seemed a significantly high percentage. At least three of these six seemed severely psychiatrically ill, and their symptoms strikingly resembled those of their parents in many respects. The illness of the parents seemed to have far-reaching impact on the adolescents' social and school life, and many of the group members unrealistically felt that they were the direct cause of their parents' illness. The most disturbing phase of the parents' hospitalization seemed to occur when discharge of the parent from the hospital was imminent, and the greatest evidence of psychiatric illness on part of several of the group members appeared at this time. This may suggest regular casework on the part of the psychiatric team with any adolescent children of psychiatric patients as discharge approaches. Further exploration of the problems of the adolescent children of psychiatric patients is suggested by these initial observations.

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CLINICAL NOTES

CRASH TRANQUILIZATION IN A
MILIEU THERAPY SETTING

HAROLD E. MOUNTAIN, M.D.,* *Staff Psychiatrist*
Fort Logan Mental Health Center, Denver, Colorado

It seems important that the disturbed (and disturbing) behavior of the severely ill psychotic patient be controlled as soon as possible--preferably within twenty-four hours of his being admitted to the therapeutic community. There are several approaches which are used to achieve this end. I propose to discuss the use of Thorazine, not as a replacement for psychological techniques, but as one contribution to the general program.

Prolonged exposure to severe psychotic symptoms may decrease the patient's chance for an early and relatively complete recovery. He may experience accumulating, irreparable ego damage. He certainly experiences accumulating and almost irreparable "social damage" to his relations with the members of the therapeutic community, who may come to identify him as "the crazy one," with the rejection, isolation, and acceptance of the sick role that accompany that label. Thorazine has an important place in the prevention of this development.

Thorazine is the drug discussed in this article only because I have had three years' experience with it, finding it most effective and without an unacceptable level of side effects. However, there may be other drugs quite as acceptable; much depends on the experience of the physician.

The principles involved in "crash tranquilization" are:

1. Give the largest dose of Thorazine that can be tolerated rather than the smallest dose possible to make the symptoms barely tolerable.

*Box 188, Fort Logan, Colorado.

2. Give the medication in full dose as soon as it can be esti-
mated. This can only be done by trial.

As soon as the patient is admitted, he is given Thorazine,
50 mgm. p.o. Serious idiosyncratic drug reactions (very rare) are
looked for. Thorazine, 50-100 mgm., is then given each hour un-
less (a) the patient is asleep; (b) the symptoms are *much* dimin-
ished; (c) serious side effect occurs. Hypotension as measured by
blood pressure is not an indication to stop medication unless
serious signs and symptoms develop.

After three or four doses are given, the hourly dose may be
doubled. After four or five more doses, it may be possible to esti-
mate the dosage indicated for the first day, so that medication can
be given q.i.d. instead of q.l hr. If oral medication is refused,
intramuscular Thorazine, 50-100 mgm., should be given in its place.
Usually after a few injections, the oral route will be elected by the
patient. Gavage can also be used in exceptional cases.

A record of medication given in this manner might read:

10 a.m. Admitted	Thorazine,	50 mgm. p.o.
11 a.m.	"	100 mgm. p.o.
12 m.	"	" " "
1 p.m.	"	" " "
2 p.m.	"	200 mgm. p.o.
3 p.m.	Asleep. Medication omitted.	
4 p.m.	Thorazine, 200 mgm. p.o.	
5 p.m.	"	600 mgm. p.o. q.i.d.
	"	200 mgm. p.o. q.l hr.
		p.r.n. agitation.

The following day Thorazine might again be increased from
2400 mgm./day to 3500 mgm./day. Within a week the daily dose
could be 5000 mgm.

Again, the main points are: (a) the largest dose tolerable;
(b) maximum dosage as soon as possible. At this stage much sleep-
iness is seen and is accepted. Although the patient is still ex-
pected to attend group activities, less involvment can be demanded
of him.

After the symptoms have been controlled for several days,
medication can be gradually withdrawn, but care is taken to prevent
re-emergence of florid symptoms. After several weeks the patient
may be completely off medication or on maintenance dosage.

PATIENT PARTICIPATION IN GROUP THERAPY REHASH

JESSICA STONE, R.N.,* *Staff Nurse*
Fort Logan Mental Health Center, Denver, Colorado

The Arapahoe County Team at the Fort Logan Mental Health Center has been conducting daily, one-hour, large group therapy sessions for almost a year. Forty to fifty patients and eight to ten staff members regularly participate in these sessions. For some time after establishing the large group, the team discussed the advisability of patient participation in the half-hour staff resume, or rehash, which follows each group session, and finally agreed to begin this program.

The decision to do this was made for various reasons. First, the patients had expressed much curiosity about what went on in these sessions. They understandably felt walled off. It was also felt that exposure to the rehash sessions could in many cases be a good learning experience for the patient.

The patients are now invited to rehash on Mondays, Wednesdays, and Fridays. The Monday and Friday rehashes are held immediately following group therapy. It is announced to the group that four patients may volunteer to attend the rehash. At times there are covert suggestions from the staff to encourage patients who have been directly concerned in the group session to attend that particular rehash.

On Wednesdays group therapy is followed immediately by recreational therapy, and the rehash following these two activities is open to all patients. The team is joined in both group and recreational therapies by the recreational therapist in order that he may help correlate and analyze pertinent material.

The patients attending rehashes are asked to remain silent for the first twenty minutes while the staff discusses the group session. They are then invited to participate in the discussion for the remaining ten minutes.

Thus far, the results of the patient participation in rehash have been very encouraging. The patients' curiosity, of course,

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*Box 188, Fort Logan, Colorado.

has been satisfied. They no longer feel isolated, and any feeling of magical staff mumbo-jumbo has been dispelled. Equally important though, participation in rehash has been effective in showing the patients what is expected of them as group members. Patients who prior to this had been adamantly nonverbal have made concerted efforts to participate and support other group members. In the rehash sessions some patients have been able to point out aspects of the group process and of individual dynamics which staff members have overlooked.

In the beginning, the greatest drawbacks to having patients attend rehash were: (a) the staff was somewhat uncomfortable and (b) the patients sometimes tended to use this time to continue group therapy. However, as we have become more accustomed to the presence of the patients, our anxiety and restraint are giving way to more frankness and confidence, and the patients are participating in the use of rehash as a means of analyzing the group process.

SCHIZOPHRENIA AND ORGANIC PHOSPHATE INSECTICIDE POISONING

DONALD G. GLASCO, M.D.,*.*Staff Psychiatrist*
Fort Logan Mental Health Center, Denver, Colorado

Perhaps alerted by Rachel Carson's recent best seller, *Silent Spring*, the lay press has lately written at length about the danger of pesticides and insecticides. The fact that the labels on these poisons have not adequately indicated their toxicity and with what precautions they should be used is well known to nurserymen. Some nurserymen are even aware of psychiatric reports which implicate organic phosphate poisoning as a causative factor in schizophrenic and manic-depressive reactions (1,5). This paper reports the case of a schizophrenic reaction in a young man whose parents

*135 East Centennial Avenue, Littleton, Colorado.

operated a nursery and were very reluctant to consider any etiology other than organic phosphate poisoning for their son's illness.

The patient was a twenty-three-year-old, single man who experienced an acute psychiatric illness in January, 1963. He believed that God talked to him; various, unidentified people were chasing him to kill him; he had hallucinations of bright lights and visions of God. He left his work as a night watchman in his father's greenhouse and asked the police for protection. He was hospitalized and treated by a private psychiatrist who described him as acutely anxious and unable to sleep, with markedly increased psychomotor and bizarre behavior. He had ideas of reference and was hallucinatory. In spite of increasingly large doses of chlorpromazine, the patient's agitated behavior continued for several days. The patient's father repeatedly raised the question of organic phosphate poisoning from insecticides which the patient had used in the greenhouse. The father pointed out that such poisoning "results in schizophrenic or manic-depressive-like illnesses." A red cell and plasma cholinesterase study (3) was done and was reported to be within normal limits. An electroencephalogram was reported to be within normal limits. Before these negative findings were reported, the patient was given 2-PAM (pyridine-2 aldoxine) (2,4). He seemed to improve dramatically: psychomotor activity quieted; he seemed not to be delusional or hallucinatory. However, within three days all the previous symptoms reappeared. When the attending psychiatrist learned of the negative test results, he believed the apparent improvement was not due to the 2-PAM but rather to the strong belief of the patient and his family that he had been poisoned and an antidote would effect a cure.

At this point the patient was referred to Fort Logan for longterm psychiatric treatment. When the parents were interviewed during the evaluation, they again discussed how their son had used phosphate insecticides and brought with them literature on insecticide poisoning. They mentioned that blood studies for insecticide poisoning had been done, said that these studies had indicated poisoning, and that the antidote had been effective temporarily. They implied that their son needed more antidote to maintain his improvement.

The patient's mental status examination revealed a young man with markedly flattened affect who admitted to auditory hallucinations and delusions of God talking to him. Speech was circumstantial and thought associations were loose. He talked at some length about his desire to be a missionary and carry the word of God to Africa.

After the patient was admitted to Fort Logan, psychosexual history and projective psychological testing revealed that he had been fairly isolated socially most of his life and saw his mother as an aggressive, castrating woman who dominated the father and son. The psychologist reported test results typical of paranoid schizophrenia. It also became apparent that the patient had begun to decompensate during his freshman year at college the previous year, when he had begun to isolate himself increasingly and was unable to maintain his studies. Rather abruptly he used his school money to finance a trip to Europe. He became preoccupied with religion and decided that he would become a missionary instead of a biologist.

The reluctance of this patient's parents to accept his illness as a bona fide schizophrenic reaction is apparent. Although they were told of the negative results of the cholinesterase and EEG studies, they were more impressed with their son's apparent, temporary improvement with the "antidote," 2-PAM. Apparently they were able to deny their roles in their son's illness by fastening onto a biochemical explanation of his symptoms, and they expected magical improvement from further use of the "antidote." The publicity given insecticide poisoning in the lay press may well facilitate denial of psychiatric illness in similar cases.

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GROUP PREPARATION OF SIX PROBLEM PATIENTS FOR FAMILY CARE

FELICE LARSEN, A.C.S.W.,* *Staff Social Worker*, and
IRENE MENDELSOHN, A.C.S.W. *Family Care Coordinator*
Fort Logan Mental Health Center, Denver, Colorado

A group consisting of six 24-hour patients, the hospital family care coordinator on the Adams County Team, and a team social worker met together once a week for two months. This group was formed to implement the team's decision that family care placement was indicated for all six. The following problems were presented by the group: rejection by immediate family, no family ties, inability to care for self due to delusional thinking, difficulty in controlling fears and anxieties, extremely poor judgment, acting out behavior in socially unacceptable ways, and numerous suicide attempts.

Of the six patients, four had previous unsuccessful family care experiences; one had never been placed; one had used previous placement to return to independent community living, but resulting pressures later necessitated readmission to the hospital.

The first few meetings encouraged expression of reactions to previous family care experiences and feelings regarding trying

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*Box 188, Fort Logan, Colorado.

again. The group members clearly felt that family care meant the end of all hope for them. They talked about being "dumped" out of the comfortable dependency of the familiar hospital into some fearful unknown where they probably would not be wanted. All but one made strong efforts to prove their illnesses were too severe to leave the shelter of the hospital. Each member devised and clung to his own unrealistic plan for future living based merely on wishful thinking. During the early meetings, too, the patients' fears of impending rejection and disaster were identified and handled, as were the ways in which they were resisting.

As they were gradually more able to identify and discuss each other's resistances, the group members were jarred into more realistic planning for themselves. As this occurred the six individuals rallied to form a cohesive group. They shared fears of rejection and allowing people to come too close. They expressed concern for one another and willingness to mutually help and support each other. Future planning was discussed and each member began to see family care more positively as a means toward achieving individual goals.

General discussions of family care and future goals gradually became more specific. Patients turned their attention to their own past roles in their families and the kind of family that might best provide for their individual emotional needs.

The realization of their own responsibility in the success of their placement produced a dramatic change. Discussion of what would happen to them gave way to thinking about ways in which they, themselves, could help to make their placements work.

Within a period of two weeks after this point had been reached all were placed in family care homes. Two patients were placed in the same home after expressing their desire to continue to help and support each other.

Taking our cue from this, the group was not dissolved. They continue to meet as a group every other week. The focus has changed to assisting each other with their present adjustment problems and towards further consideration of future planning. In addition to the patient group, the caretakers also meet as a group to assist each other with the problems of absorbing these patients into their families.

Although it is still too early to evaluate the continuing success of these placements, it does seem that the group was beneficial in helping these multiproblem patients to move into family care. As needed on the team, new family care preparation groups being planned.

THE DEVELOPMENT OF AN INTERTEAM
HOSPITAL PROGRAM

NURI ASSAFI, PH.D.,* *Staff Psychologist*
and Evening Hospital Staff of
Denver-2 and Arapahoe County Teams**
Fort Logan Mental Health Center, Denver, Colorado

The creation of an evening hospital program at the Fort Logan Mental Health Center is congruent with the center's philosophy of encouraging patients to retain the maximum amount of their normal responsibilities and enabling them to assume further responsibilities as soon as is therapeutically feasible. The evening hospital program is designed to help those patients who have progressed enough in their treatment program to resume work or schooling, as well as meeting the treatment needs of new patients who are able to continue work or school while receiving treatment. It offers more intensive treatment than would be available on an outpatient basis.

THE PROGRAM

Although an evening hospital program had been initiated by other teams at Fort Logan individually, the two teams occupying F-2 Cottage explored the idea of initiating a combined evening

*Box 188, Fort Logan, Colorado.

**Ann Watson, R.N., Georgianne Robinson, M.S.W., Sue Dodson, M.S.W., Sally Winters, Psychiatric Technician, and Angie McNeill, R.N.

hospital program. The idea grew out of the fact that the two teams
had developed a pattern of cooperation and harmony in overcoming
the problems that necessarily arose from their sharing the same
cottage. It was also felt that drawing the staff from both teams for
such a program would reduce the burden that would be placed on
each of them. After several months of planning, the many obsta-
cles that stood in the way of initiating such a program were re-
solved, and the first evening hospital session took place on April 15,
1963.

The evening hospital program operates from 6 to 9 p.m. on
Mondays, Tuesdays, and Thursdays. Two staff members, one from
each team, are on duty one evening a week. Because of the limited
number of staff, a maximum of twenty patients in the program has
been set, ten from each team. To facilitate communication, sum-
maries are written at the end of each session and made available
to all the evening hospital staff members. Moreover, a weekly meet-
ing of all the members is held. During these meetings, the progress
of each patient is discussed and recorded, and matters concerning
the program are discussed.

The program and the staff members participating in it are out-
lined in Table 1.

TABLE 1

EVENING HOSPITAL PROGRAM AND STAFF

DAY	TEAM I	TEAM II	PROGRAM
Monday	Head Nurse	Psychologist	Group Therapy, OT
Tuesday	Psych. Tech.	Social Worker	Psychodrama, RT
Thursday	Social Worker	Nurse	Group Psychotherapy, RT

The program on Thursdays is also open to the immediate fami-
lies of the patients, including spouses, parents, and grown-up chil-
dren. In addition to the staff members listed, the team leader (psy-
chiatrist) of one of the teams acts as a consultant to the program.

Although the evening hospital program is for the most part an
autonomous treatment operation, the two teams remain responsible

for their individual patients. The possibility of movement between the evening program and other programs, such as 24-hour care, day care, and outpatient care, is always present.

This has been a very brief description of the combined evening hospital program of the Arapahoe and Denver-2 Teams. A similarly brief and subjective evaluation seems to suggest that such a co-operative effort has not only proved to be possible, but that the program has been effective. In a subsequent article, we hope to present a more detailed picture of the program, the problems that have arisen, and a critical evaluation of its results.

CORRESPONDENCE

To the Editor:

The people of the state of Colorado have in the Fort Logan Mental Health Center one of the finest hospitals in the United States.

Those of us who are charged with its operation and management have a tremendous responsibility. It is our obligation to provide in the Denver and Tri-County area a treatment program second to none. Not only the eyes of Colorado, but the eyes of the nation are focused upon us. I am confident that we can be equal to these expectations.

In order to meet this obligation, we must take advantage of every opportunity to tell the Fort Logan story factually and fairly. I believe that in the Journal, of which this note will become a part, we are taking a step in this direction. I have had a preview of the contents of the Journal and wholeheartedly endorse it. I trust that it may be placed in the hands of many responsible people so that Fort Logan Mental Health Center may continue to add its contribution in our struggle to alleviate mental illness in this area.

David A. Hamil
Director
Department of Institutions
State of Colorado

EDITORIAL*

CRITERIA OF SUCCESS AND FAILURE IN THE TREATMENT
OF THE MAJOR MENTAL ILLNESSES

A patient recently came to the Fort Logan Mental Health Center when his wife threatened to divorce him. His therapists set treatment goals which included helping him with his sexual problems and teaching him more appropriate, masculine ways of asserting himself. The patient set his treatment goal as getting his wife back. He left Fort Logan when this was accomplished, grateful for the success of treatment. His therapists, however, regarded him as a treatment failure.

One of the major obstacles to the scientific evaluation of treatment methods for the major mental illnesses is the absence of clear criteria for what constitutes therapeutic success or failure. Statistics such as discharge rates, readmission rates, and length of stay in hospital have traditionally been used as criteria of the effectiveness of treatment modalities such as electroshock, therapeutic community, and CO_2 inhalation. But in the foreseeable future, the great majority of hospitalized psychiatric patients will be discharged in a short time. Criteria centered around the presence or absence of the patient in the hospital will then be inadequate. We will be faced with the thorny problem of developing criteria of positive mental health for the major mental illnesses.

Recent studies have moved in this direction by using measures such as behavioral ratings of patients, work adjustment, and questionnaires filled out by relatives to evaluate the success of psychiatric treatment. But too often such criteria are derived from evaluations of individual psychotherapy with neurotics, and apply only partially to the major mental illnesses. To further complicate the situation, studies using several different criteria indicate that

*From time to time, editorials will appear in the Journal of the Fort Logan Mental Health Center on topics pertinent to the treatment of the major mental illnesses.

success, or failure, is not unidimensional. A patient may improve his work adjustment in treatment, but his marital adjustment may deteriorate at the same time.

In developing criteria of positive mental health for the major mental illnesses, whose value systems should be given priority? The most commonly used indices of improvement in psychiatric treatment have their source in values held by therapists. In an exploratory study at the Fort Logan Mental Health Center, we asked clinicians to describe and discuss their criteria for treatment success and failure and found wide divergence of opinion, often among clinicians on the same therapeutic team. How much weight should be given to the patient's own values of what constitutes success in treatment? Finally, how much emphasis should be given to the values of the patient's relatives, his employers, and other community members, who are often instrumental in bringing the patient to the hospital in the first place?

Descriptive research exploring criteria of positive mental health for the major mental illnesses seems long overdue.

Paul Polak, M.D.

NOTICE TO CONTRIBUTORS

The *Journal of the Fort Logan Mental Health Center* invites contributions in the areas of milieu therapy, social psychiatry, and related fields.

Manuscripts should be submitted in triplicate in the form in which the author wishes the paper to appear. Copy should be double-spaced, with margins of at least one and one-fourth inches.

References should be indicated by numbers in parentheses that refer to the list of references at the end of the article. The list should be alphabetical, and the names of the journals should not be abbreviated. The following format should be observed:

JAHODA, MARIE, "Current Concepts of Positive Mental Health," New York, Basic Books, 1958.

RIESMAN, D., "Some Observations on Interviewing in a State Mental Hospital," Bulletin of the Menninger Clinic, Vol. 23, pp. 7-19, 1959.

The author should include an address to which inquiries regarding the article should be sent, in the form of a footnote indicated by an asterisk on the first page of the article.

Manuscripts should be addressed to Paul Polak, M.D., Editor, Journal of the Fort Logan Mental Health Center, Box 188, Fort Logan, Colorado. Reprints will be furnished at the author's expense.